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In The

Supreme Court of the United States

METLIFE (METROPOLITAN LIFE INSURANCE COMPANY) AND LONG TERM DISABILITY PLAN FOR ASSOCIATES OF SEARS, ROEBUCK AND COMPANY,

Petitioners,

v.

WANDA GLENN,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit

BRIEF FOR NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENT

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INTEREST OF *AMICUS CURIAE*[1]

The National Association of Insurance Commissioners ("NAIC") is a non-profit corporation whose membership consists of the principal insurance regulatory officials of the fifty States, the District of Columbia, the territories and insular possessions of the United States. Founded in 1871, it is the nation's oldest association of state government officials. The NAIC represents the coordinated and considered views of the state government officials that regulate and enforce the insurance laws of the country.

The NAIC's purpose is to provide its members with a national forum enabling them to work cooperatively on regulatory matters that transcend the boundaries of their own jurisdictions. Collectively, the state insurance commissioners work to develop model legislation, rules, regulations, white papers and actuarial guidelines that promote and establish uniform regulatory policy. Their overriding objectives are to protect consumers as well as assist in maintaining the financial stability of the insurance industry.

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[1] No counsel for a party authorized this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *amicus curiae*, its members, or its counsel made a monetary contribution to its preparation or submission. Counsel of record for all parties received notice at least ten days prior to the due date of the *amicus curiae's* intention to file this brief. Counsels for Petitioners and Respondent have submitted letters to the Clerk of the Court consenting to the filing of all *amicus* briefs in this case.

The NAIC performs numerous crucial services on behalf of state governments including: developing and publishing model laws, regulations, bulletins, financial and accounting standards, white papers, consumer guides, handbooks, periodicals and the *Proceedings of the NAIC*. Hundreds of state and federal laws assign duties to the NAIC and incorporate NAIC standards, models and other publications. In addition, the NAIC manages and coordinates the accreditation review of insurance departments as well as maintains regulatory and financial databases of insurance company financial data.

The interest of the NAIC in this case arises out of the regulatory responsibility vested in each commissioner over health insurance and disability income protection coverage. The insurance commissioners of the various states are charged by state and federal law with the responsibility of regulating the business of insurance within their respective jurisdictions pursuant to the McCarran-Ferguson Act of 1945, 15 U.S.C. § 1011, *et seq.* ("McCarran-Ferguson Act"), and state insurance laws. The authority to regulate insurance issued in connection with employee welfare benefits plans is reserved to the states through the savings clause of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001, *et seq.* ("ERISA"). 29 U.S.C. § 1144(b)(2)(A).

The Court granted limited certiorari to hear this case on the questions of (1) whether a claim administrator of an ERISA plan that also funds the plan benefits (sometimes referred to as a "dual-role

administrator"), without more, has a conflict of interest which must be weighed in a judicial review of the administrator's benefit determination; and (2) if this is in fact a conflict, how that conflict should be taken into account on judicial review of a discretionary benefit determination. *MetLife v. Glenn*, 128 S.Ct. 1117 (2008). The specific ERISA plan at issue in this case provided benefits through a long-term disability insurance policy containing the following discretionary clause:

> In carrying out their respective responsibilities under the Plan, the Plan Administrator and other Plan fiduciaries shall have the discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious. J.A. 148a, 181a.

The NAIC adopted the Prohibition on the Use of Discretionary Clauses Model Act, 1 NAIC *Model Laws, Regulations and Guidelines,* 42-1 to 42-6 (2002, amended 2004) ("Discretionary Clause Model Act"), that bans discretionary clauses in health insurance and disability income protection coverage partly because of the inherent conflict of interest that exists when an insurer responsible for providing benefits has discretionary authority to decide what benefits are due.

The Executive Committee of the NAIC voted to file this *amicus* brief to emphasize the need for sound regulation and judicial review when the benefit payor makes its own determinations on benefit claims. Through the passage of the Discretionary Clauses Model Act, the NAIC and its members have made the policy determination that the best way to address this conflict from a public policy perspective is to prevent it. By removing discretionary clauses from insurance policies, state insurance regulators assure that disputes concerning health insurance benefits and disability income protection coverage are resolved fairly, based on evidence; state insurance regulators also eliminate the conflict of interest that occurs when the carrier responsible for providing benefits has discretionary authority to decide what benefits are due.

Despite the NAIC model, many policies that contain discretionary clauses remain on the market. In such cases, should claim denials be reviewed deferentially? Because of the conflict of interest inherent in such claims review, the NAIC would answer, "No." Application of a *de novo* standard of review would promote fair claims handling practices and place the rights and duties of the parties in a group setting on the same footing with the rights and duties of the parties in all other insurance proceedings.

SUMMARY OF ARGUMENT

The Court of Appeals correctly held that Petitioner MetLife (Metropolitan Life Insurance Company) acted under a conflict of interest and its decision to deny long-term disability benefits to Respondent Wanda Glenn was not the product of a principled and deliberative reasoning process. The questions to be addressed by the Court on certiorari raise several issues that are of general and national concern to the membership of the NAIC:

1. In approving the Discretionary Clauses Model Act, the NAIC has made a policy determination that there is an inherent conflict of interest with respect to health insurance and disability income protection coverage that occurs when the carrier responsible for providing benefits has discretionary authority to decide what benefits are due. Recognition by the Court of this policy consideration would resolve the current split between the Circuits by adopting the reasoning of the Sixth Circuit that a plan administrator that both funds and administers the plan acts in a dual function that creates an inherent conflict of interest. *Glenn v. MetLife,* 461 F.3d 660, 666 (6th Cir. 2006).

2. Petitioners argue that the realities of the insurance business confirm that a company that evaluates and pays claims does not operate under a conflict of interest which must be weighed on judicial review. However, the 2004 multistate market conduct examination conducted with respect to disability

claims handled by UnumProvident Corporation ("Unum"), in which Unum agreed to a $140 million settlement and a $15 million penalty, provides ample evidence that these conflicts are real and must be recognized by the Court.

3. If the Court recognizes that the conflict of interest is inherently present when the administrator is the insurer on risk for the claim, a *de novo* standard of review should be used to review claim denials (despite any discretionary clause). Application of this standard is necessary to promote fair claims handling practices and place the rights and duties of the parties in a group setting on the same footing with the rights and duties of the parties in all other insurance proceedings.

4. When the administrator is the insurer on risk for the claim, the Court should reconsider its decision that abuse-of-discretion review applies if "the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). The analogy to trust law on which the Court based this portion of its decision is unsound in these circumstances, and it is contrary to the protective intent of ERISA to allow plan drafters to dictate reduced scrutiny for conflicted plan fiduciaries in contested insurance benefit denial cases.

ARGUMENT

1. THERE IS AN INHERENT CONFLICT OF INTEREST WHEN THE DUAL-ROLE INSURANCE CARRIER HAS DISCRETIONARY AUTHORITY TO DECIDE WHAT BENEFITS ARE DUE.

ERISA was enacted to "protect . . . the interests of participants in employee benefit plans and their beneficiaries . . . by establishing standards of conduct, responsibility, and obligation for fiduciaries of [those] plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C. § 1001(b). As part of ERISA's comprehensive enforcement scheme, § 502(a)(1)(B) authorizes a plan participant or beneficiary to bring a civil action "to recover benefits due to him under the terms of his plan." 29 U.S.C. § 1132(a)(1)(B).

In *Firestone*, the Court considered the appropriate standard of review in an action to recover benefits under an ERISA plan. *Firestone* held that courts would presumptively review ERISA benefit determinations *de novo,* but stated that "a deferential standard of review [is] appropriate" when the decisionmaker is given "discretionary powers." *Firestone*, 489 U.S. at 115. If the plan documents expressly give the administrator discretionary authority, then the administrator's decisions are final and could be challenged only for abuse of discretion, *i.e.*, if the administrator's decision was arbitrary and capricious. In general, under *Firestone* judicial deference is accorded to the decisions of administrators who have

been given discretionary authority. *See Kearney v. Standard Ins. Co.*, 175 F.3d 1084, 1089 (9th Cir. 1999). In light of *Firestone*, the standard industry practice has been to include discretionary clauses in insurance contracts to ensure that a court uses a deferential standard of review, except where such clauses are prohibited by state law.

The Court in *Firestone* tempered its decision by noting that "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'factor in determining whether there is an abuse of discretion.'" 489 U.S. at 115 (quoting Restatement (Second) of Trusts § 187, cmt. d (1959)). Since the *Firestone* decision in 1989, the circuits have struggled to construe this command, and apply it to benefit decisions by insurance carriers which, by definition, labor under a structural conflict of interest. The circuits disagree both on whether conflicted decision-making by insurers may be presumed or must be proven through direct evidence of taint, and on how to take any conflict into account in reviewing insurance company decisions.

The *amicus* brief of the United States filed by the Solicitor General in this case on petition for writ of certiorari provides an excellent discussion of the circuit split on the first question presented by this Court; i.e., whether the fact that a claim administrator of an ERISA plan also funds the plan benefits, without more, constitutes a conflict of interest which must be weighed in a judicial review of the administrator's

benefit determination. U.S. *Amicus* Br. 7-8. Without providing an in-depth analysis of the position of each circuit and the authority upon which it relies, the NAIC encourages this Court to adopt the position taken by the Sixth Circuit that a plan administrator that both funds and administers the plan is performing a dual function that creates an apparent conflict of interest. *See Glenn,* 461 F.3d at 666.

The Sixth Circuit explained the basis for the approach taken in *Glenn* in a prior decision, reasoning that a plan administrator that both funds and administers the plan operates under a direct conflict because it has a financial incentive to deny benefits because it "incurs a direct expense as a result of the allowance of benefits," and it "benefits directly from the denial or discontinuation of benefits." *Killian v. Healthsource Provident Adm'rs, Inc.*, 152 F.3d 514, 521 (6th Cir. 1998). U.S. *Amicus* Br. 7.

The NAIC originally passed the Discretionary Clauses Model Act in 2002 prohibiting the use of discretionary clauses in health insurance policies. 1 Proc. of the Nat'l Ass'n of Ins. Comm'rs 4, 12-13 (2002). Among the reasons cited were that the NAIC membership believed that discretionary clauses were inconsistent with basic insurance consumer rights. 4 Proc. of the Nat'l Ass'n of Ins. Comm'rs 2290 (2003). The stated purpose of the Model Act was to assure that the reasonable expectations of the claimant would be protected under an objective, contract-based standard for claims. Prohibition on the Use of Discretionary Clauses Model Act, Technical Amendment

and Project History. 2 Proc. of the Nat'l Ass'n of Ins. Comm'rs 10, 17 (2002).

In 2004 the NAIC extended this prohibition to disability insurance. 4 Proc. of the Nat'l Ass'n of Ins. Comm'rs 57 (2004). In addition to the rationale cited above, the NAIC considered the long-standing principle that any ambiguities in an insurance policy must be interpreted in favor of the insured person. Currently 11 states (California, Hawaii, Illinois, Indiana, Michigan, Maine, Montana, New Jersey, New York, Oregon and Utah) have adopted some type of prohibition against discretionary clauses in either health (sometimes called "disability" or "accident and sickness" coverage in insurance codes) or disability income insurance policies.[2] Recent District Court

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[2] *See* ME. REV. STAT. ANN. tit. 24-A § 4303 (1995); ILL. ADMIN. CODE tit. 50, § 2001.3 (2005); MICH. ADMIN. CODE r. 500.2201-2202 (2007); N.J. ADMIN. CODE § 11:4-58 (2007); UTAH ADMIN. CODE r. 590-218 (2003); *Am. Counc. of Life Ins. v. Watters*, 2008 WL 541654 (W.D. Mich. 2008); *Standard Ins. Co. v. Morrison*, 2008 WL 510043 (D. Mont. 2008); Notice, Cal. Dep't of Ins., Notice to Withdraw Approval and Order for Information (Feb. 27, 2004), *available at* www.insurance.ca.gov/0250-insurers/0300-insurers/0200-bulletins/bulletin-notices-commiss-opinion/upload/Notice-February-27-2004.pdf (last visited Mar. 26, 2008); Commissioner's Memorandum 2004-13H from the Hawaii Dep't of Ins. On Discretionary Clauses in HMSA's Agreement for Group Health Plan and Guide to Benefits (Dec. 8, 2004), *available at* http://hawaii.gov/dcca/areas/ins/commissioners_memo/ (last visited Mar. 26, 2008); Bulletin 103 – Full and Final Discretion Clauses in Group Health Contracts (Ind. Dep't of Ins. June 8, 2001), *available at* http://www.in.gov/idoi/lookAtTheLaw/pdfs/Bulletin 103.pdf (last visited Mar. 26, 2008); Circular Letter No. 14 (State of N.Y. Ins. Dep't June 29, 2006), *available at* www.ins.state.ny.

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decisions in Montana and Michigan confirm that rules prohibiting discretionary clauses in insurance policies sold in these states were saved from preemption as laws regulating insurance under ERISA's savings clause. *See Am. Counc. of Life Ins. v. Watters*, 2008 WL 541654 (W.D. Mich. 2008); *Standard Ins. Co. v. Morrison*, 2008 WL 510043 (D. Mont. 2008).

The NAIC's members develop model laws and regulations to serve as standards for the promulgation of insurance laws and regulations in individual states. Consistent with its mission, the NAIC helps its members and their respective insurance departments explain the function and significance of NAIC model laws and regulations to legislatures, courts, other divisions of the executive branch, industry, consumers and the general public. The public policy behind the NAIC's Discretionary Clauses Model Act is clearly stated in *Section 2. Purpose and Intent*:

> The purpose of this Act is to assure that health insurance benefits and disability income protection coverage are contractually guaranteed, and to avoid the conflict of interest that occurs when the carrier responsible for providing benefits has discretionary authority to decide what benefits are due. Nothing in this Act shall be construed as

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us/cl06_14.htm (last visited Mar. 26, 2008); Standard Provisions for Long and Short Term Disability Group or Individual (Or. Ins. Div. Apr. 5, 2005), *available at* www.oregoninsurance.org/docs/serff/2447.pdf (last visited Mar. 26, 2008).

> imposing any requirement or duty on any person other than a health carrier or insurer that offers disability income protection coverage.

The U.S. Congress charged state insurance commissioners with great responsibility in enacting the McCarran-Ferguson Act by reserving to the states the authority to regulate the business of insurance. NAIC members have acted accordingly in adopting the Discretionary Clauses Model Act, which recognizes that there is an inherent conflict of interest in dual role administrators. This Court should give due deference to the collective experience of the members of the NAIC who are entrusted to regulate disability income protection insurance coverage, and find that a claim administrator of an ERISA plan that also funds the plan benefits constitutes a conflict of interest which must be weighed in a judicial review of the administrator's benefit determination. Accordingly, this Court should affirm the opinion of the Sixth Circuit in this matter finding that Respondent had an apparent conflict of interest in this case.[3]

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[3] The case currently before this court involves a discretionary clause in a group long term disability policy, over which the NAIC members have jurisdiction under the McCarran-Ferguson Act and the ERISA savings clause. 29 U.S.C. § 1144(b)(2)(A). The NAIC's Discretionary Clauses Model Act similarly only addresses disability insurance policies, and not self-funded plans or administrative services supplied to self-funded plans by disability insurance carriers. Therefore, the NAIC does not express an

(Continued on following page)

2. PETITIONERS' ARGUMENT THAT THE REALITIES OF THE INSURANCE BUSINESS CONFIRM A COMPANY THAT BOTH EVALUATES AND PAYS CLAIMS DOES NOT OPERATE UNDER A CONFLICT OF INTEREST IS CONTRADICTED BY THE UNUM MULTISTATE EXAMINATION.

In support of their argument that a company that pays claims does not, for that reason alone, operate under a conflict of interest that must be weighed on judicial review, Petitioners argue that the realities of the insurance business confirm such a dual-role company does not operate under a conflict of interest. Pet'r Br. 29. Petitioners argue any potential conflict inherent in an insurance company's evaluation and payment of claims is counterbalanced by the fact that insurers have powerful long-term business incentives to treat claimants fairly. Pet'r Br. 29-33.

The Petitioner's arguments are not new to either insurance regulators or the courts, and at least one commentator has referred to them as "deeply flawed." John H. Langbein, *Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials under ERISA*, 101 NW. U. L. REV. 1315, 1327 (Spring 2007). Prof. Langbein goes on to refute each of Petitioners' arguments, addressing them through both legal theory and real life experience. For

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opinion to the Court on the effect of discretionary clauses in self-funded ERISA disability plans.

example, with respect to Petitioners' argument comparing an insurance company claim administrator with a social security examiner (Pet'r Br. 32), Prof. Langbein cites to *Herzberger v. Standard Ins. Co.*, 205 F.3d 327, 332 (7th Cir. 2000), in which the court observed that the Social Security Administration "is a public agency that denies benefits only after giving the applicant an opportunity for a full and fair adjudicative hearing. The procedural safeguards thus accorded, designed to assure a full and fair hearing, are missing from determinations by [ERISA] plan administrators."

However, the best real-life example provided by Prof. Langbein is a matter that is very familiar to the NAIC and its members: The Report of the Targeted Multistate Disability Income Market Conduct Examination (Feb. 29, 2004) ("Unum Multistate Examination Report").[4]

Unum/Provident Corporation ("Unum"), the largest disability insurance company in the United States, had been the target of nearly 3,000 lawsuits, in addition to a 2002 class action suit alleging that Unum was unfairly and deliberately denying disability claims. Many federal courts have commented on Unum's aggressive claims denial practices during this time, speaking about Unum's selective review of the administrative record, lack of objectivity, abuse of discretion, misuse of ambiguous test results, and

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[4] *Available at* http://maine.gov/pfr/insurance/unum/Unum_Multistate_ExamReport.htm (last visited Mar. 26, 2008).

claims evaluation practices that defied common sense and bordered on outright fraud. Langbein, 101 NW. U. L. REV. at 1320.

The NAIC coordinated a multistate market conduct examination by its members starting in 2003, focusing on Unum claims practices. In November 2004, Unum (without admitting, denying or conceding any actual or potential fault) signed an agreement with the insurance commissioners of Massachusetts, Maine, and Tennessee in which Unum settled allegations related to systematic irregularities found in its claim handling practices for both individual and group disability claims. *See* Unum Multistate Examination Report at Paragraph C.12. Forty-seven other states and the District of Columbia joined the three lead states in the multistate market conduct examination of Unum Life Insurance Company of America, The Paul Revere Life Insurance Company, and Provident Life and Accident Insurance Company. The U.S. Department of Labor, which conducted a related investigation of Unum's practices involving employee benefit plans covered by ERISA, was also a party to the settlement, and New York's Attorney General also endorsed the settlement. *See* Joint Press Release, Multi-State Settlement Addresses Concerns Regarding Unum-Provident Claims Handling (Nov. 18, 2004) ("Multistate Settlement Announcement").[5]

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[5] *Available at* http://www.state.tn.us/commerce/pdf/press/prsRls111804.pdf (last visited Mar. 26, 2008).

The Unum Multistate Examination Report, which was issued after Unum had lost several high-profile disability claim cases, included a $140 million settlement and a $15 million fine against Unum. California, which settled separately with Unum, imposed an additional $8 million civil penalty. California Settlement Agreement, File No. DISP05045984.[6] The Multistate Settlement Announcement identified several claims handling practices of concern to state regulators:

- Excessive reliance on in-house medical staff to support the denial, termination, or reduction of benefits;
- Unfair evaluation and interpretation of attending physician or independent medical examiner reports;
- Failure to evaluate the totality of the claimant's medical condition; and
- An inappropriate burden placed on claimants to justify eligibility for benefits.

The Unum Multistate Examination Report has been referred to as one of the most significant multistate insurance regulator actions in NAIC history,[7] and it stands as a startling example of what can occur

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[6] *Available at* http://www.secinfo.com/d14D5a.z5UXk.d.htm #1stPage (last visited Mar. 26, 2008).

[7] *See* Multistate Settlement Announcement, quoting then Maine Insurance Superintendent Alessandro Iuppa.

when a rogue insurance company uses ERISA as a shield to protect the nonpayment of legitimate claims. In the course of discovery proceedings against Unum, an internal memorandum written by a Unum executive was uncovered illustrating this point:

> A [company] task force has recently been established to promote the identification of [disability] policies covered by ERISA and to initiate active measures to get new and existing policies covered by ERISA. The advantages of ERISA coverage in litigious situations are enormous: state law is preempted by federal law, there are no jury trials, there are no compensatory or punitive damages, relief is usually limited to the amount of benefit in question, and claims administrators may receive a deferential standard of review. The economic impact on [company] from having policies covered by ERISA could be significant. As an example, [a company employee] identified 12 claim situations where we settled for $ 7.8 million in the aggregate. If these 12 cases had been covered by ERISA, our liability would have been between zero and $ 0.5 million.
>
> In order to take advantage of ERISA protection, we need to be diligent and thorough in determining whether a policy is covered. **[While] our objective is to pay all valid claims and deny invalid claims, there are gray areas, and ERISA applicability may influence our course of action.** [Emphasis added]. Mark D. DeBofsky,

Disability Insurance Under the ERISA Law: Economic Security or Litigation Nightmare, 25 J. Ins. Reg. 33, 37-38 (Spring 2007).

Please note that the NAIC is not alleging or implying that Petitioners have been engaged in the same type of inappropriate claim practices as were found against Unum, nor are we making a general statement that these practices are common in the insurance industry. However, Unum's unscrupulous conduct demonstrates the fallacy of Petitioners' argument that market forces are sufficient to deter wrongful claim denial. *See Dishman v. Unum Life Insur. Co. of America,* 1997 WL 906147 10 (C.D. Cal. May 9, 1997), *affirmed in part and denied in part,* 296 F.3d 974 (9th Cir. 2001).

3. WHEN THE ADMINISTRATOR IS THE INSURER ON RISK FOR THE CLAIM, THERE IS AN INHERENT CONFLICT OF INTEREST PRESENT, AND A *DE NOVO* STANDARD OF REVIEW MUST BE USED TO REVIEW THE CLAIM DENIAL.

The second question for which the Court granted certiorari is, as follows: "If an administrator that both determines and pays claims under an ERISA plan is deemed to be operating under a conflict of interest, how should that conflict be taken into account on judicial review of a discretionary benefit determination?" *MetLife v. Glenn,* 128 S.Ct. 1117 (2008). Again, the *amicus* brief of the United States filed in this case on writ of certiorari provides an excellent discussion

on the circuit split on the second question presented by this Court. U.S. *Amicus* Br. 9-11.

In adopting the Discretionary Clauses Model Act, which prohibits discretionary clauses in health and disability insurance policies, the NAIC has implicitly recognized that the administrator's decision should be subject to independent *de novo* review, in keeping with the resolution of other insurance disputes.

The Court in *Firestone* recognized that "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'factor in determining whether there is an abuse of discretion.'" *Firestone*, 489 U.S. at 103. However, the approaches currently utilized by the circuits do not adequately address the issues that such a conflict raises, such as disability insurance companies using ERISA as a shield to avoid liability, as addressed in the Unum Multistate Examination Report.

The NAIC does not believe that deferential review of claim denials by dual-role companies affords "a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review" as required by ERISA. 29 U.S.C. § 1133(2). A "full and fair review" demands that an aggrieved claimant be allowed to challenge a claim denial in court under a *de novo*[8] standard of review.

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[8] Some cases and commentators have suggested that the standard of review should actually be plenary, and not *de novo*.

(Continued on following page)

NAIC membership is of the view that permitting a group disability insurance policy to intentionally skew the standard of review against the claimant in any way interferes with the protective purpose of insurance regulatory law.

4. THE COURT SHOULD RECONSIDER ITS DECISION THAT ABUSE-OF-DISCRETION REVIEW APPLIES IF "THE BENEFIT PLAN GIVES THE ADMINISTRATOR OR FIDUCIARY DISCRETIONARY AUTHORITY TO DETERMINE ELIGIBILITY FOR BENEFITS OR TO CONSTRUE THE TERMS OF THE PLAN."

Since this Court issued its opinion in *Firestone,* a number of ERISA scholars and commentators have suggested the Court's decision allowing discretionary clauses to be given effect in insurance policies was not based on sound trust law principles or the realities of the insurance marketplace. When the administrator is the insurer on risk for the claim, the Court should reconsider its decision that abuse-of-discretion review applies if "the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Firestone,* 489 U.S. at 115. The analogy to trust law on which the Court based this portion of its

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See Diaz v. Prudential Ins. Co. of America., 424 F.3d 635, 637 (7th Cir. 2005); and DeBofsky, 25 J. Ins. Reg. at 39.

decision is unsound in these circumstances, and it is contrary to the protective intent of ERISA to allow plan drafters to dictate reduced scrutiny for conflicted plan fiduciaries in contested insurance benefit denial cases.

In *Firestone,* this Court was construing the terms of a self-funded employee benefit plan established by an employer, which was directly responsible for the payment of the plan benefits it had chosen to grant to its employees. *Firestone,* 489 U.S. at 101. In the instant case, by contrast, the employer provided benefits by purchasing an insurance policy, a contract under which a third party insurance company agrees to pay contractually defined benefits. Under this contract, the insurer assumes the risk of profit or loss depending on whether the cost of those benefits turns out to be higher or lower than predicted when pricing the insurance contract. If the insurer pays more claims than anticipated, its remedy is to either raise premiums or limit the scope of coverage for future policy terms, not to exercise discretion and in effect change the rules it has contractually agreed upon for the current term. In these circumstances, the "fiduciary obligation" language of ERISA must be seen as complementing contract law, not replacing it.

Giving the insurer the discretion to interpret its own policy form flies in the face of one of the fundamental principles of insurance law, that any ambiguities that might arise in insurance policies must be resolved so as to honor the reasonable expectations of the insured. This principle arises out of the

common-law doctrine of *contra proferentem* but has been adopted into state law that regulates insurance. *See Leibrand v. Nat'l Farmers Union Prop. and Cas. Co.*, 898 P.2d 1220, 1223 (Mont. 1995) (citing *Bauer Ranch, Inc. v. Mountain West Farm Bureau*, 695 P.2d 1307, 1309 Mont. 1985). State courts have unanimously held that ambiguous policy language must be liberally interpreted in favor of the policyholder and strictly construed against the insurer. 2 Eric Mills Holmes, HOLMES' APPLEMAN ON INS. 2d § 6.1, p. 134 and n. 4 (1996) (citing cases from 37 states).

In *Pilot Life Insurance Co. v. Dedeaux,* 481 U.S. 41 (1987), this Court first held that ERISA preempts state law claims for bad faith breach of an insurance contract and the accompanying punitive damages awards. However, it was not the preclusion of punitive damages alone that led to the current situation, as illustrated by the Unum Multistate Examination Report. The real transformation of insurance claims governed by ERISA occurred after this Court's decision in *Firestone,* which had the effect of conferring a special status on insurers who issue group policies giving them unparalleled authority to determine claims in their discretion. DeBofsky, 25 J. Ins. Reg. at 38.

"In enacting ERISA, Congress' primary concern was with the mismanagement of funds accumulated to finance employee benefits and the failure to pay employees benefits from accumulated funds." *Massachusetts v. Morash,* 490 U.S. 107, 115 (1989). Through ERISA Congress responded to these dangers by imposing fiduciary standards derived from private

trust law for the administration of all employee benefit pans. In his seminal article on the application of discretionary clauses in disability insurance policies, Prof. Langbein thoroughly analyzes the reliance on trust law in the *Firestone* opinion, and finds it misplaced for a variety of reasons. Langbein, 101 NW. U. L. REV. at 1325-1342. Specifically, he points out dual-role administrators are different from traditional trustees in at least one important way:

> Although "ERISA abounds with the language and terminology of trust law," ERISA fiduciary law differs markedly from conventional trust law in one crucial respect. Trust law presupposes that the trustee who administers a trust will be disinterested, in the sense of having no personal stake in the trust assets, although the trust terms can make contrary provision. By contrast, ERISA fiduciaries are commonly aligned with the employer (or, in most plans that supply insurance benefits, with the insurance company to which the employer delegates administrative responsibilities for the particular plan). *Id.* at 1326.

To the extent that the term "administrator" implies a disinterested third party that is capable of objectively evaluating the merits of a claim, the whole concept of a dual-role administrator is an oxymoron. Insurers are not merely administrators, and it is not realistic to expect them to be disinterested; it is not fair to the insurers to demand that they be disinterested. Instead, it is necessary to adopt both a

regulatory framework and a standard of review that accepts the immutable fact that insurers are interested parties.

This Court has acknowledged that "[b]eyond the threshold statement of responsibility, however, the analogy between ERISA fiduciary and common law trustee becomes problematic. This is so because the trustee at common law characteristically wears only his fiduciary hat when he takes action to affect a beneficiary, whereas the trustee under ERISA may wear different hats." *Pegram v. Herdrich*, 530 U.S. 211, 225 (2000). The flaw in *Firestone*, when applied to insurance companies writing group coverage, is found in this distinction: the common-law trustee is administering a fixed pool of assets, unlike the insurer, which has promised to pay any and all claims under the policy, even if those claims exceed the amount of premiums that were collected.

More importantly, the common-law trust paradigm is based on the expectation that giving the trustee discretionary powers is in the best interest of the beneficiaries as a class, if not specifically in the interest of each individual beneficiary. For example, when a wealthy benefactor endows a trust to provide financial assistance with medical care for family members, each dollar that is spent on one beneficiary is a dollar that is no longer free to spend on another. This is not the case with respect to an insurance policy. Insurance coverage involves no separate trust corpus that requires protection and measured distribution. The payment of benefits

under an insurance policy is a contractual entitlement, not a gratuity.

Therefore, this Court should reconsider the wisdom of the underlying *Firestone* rationale in light of the current realities of claim handling practices in its consideration of the issues before it in this case as applied to fully insured group health and disability income insurance coverage.

CONCLUSION

For the foregoing reasons, the judgment below should be affirmed.

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